

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Exton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Thomas Robinson

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ada E. Robinson6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) Sept. 3, 1877

8. AGE:

Years

Months

Days

If less than one day

71017

hrs.

min.

9. Birthplace

Exton, Kent, Maryland
(Town, county, and state)

10. Usual occupation

Retired Merchant

11. Industry or business

John T. Robinson

FATHER

12. Name

Jos.

13. Birthplace

Adams, Illinois

MOTHER

14. Maiden name

Mrs.

15. Birthplace

Adams, Illinois

16. Informant

Exton, Maryland

Address

Exton

17. (Burial, cremation, or removal, which?)

Spring HillDate thereof September 20, 1948
(month) (day) (year)

Cemetery or crematory

Exton, Maryland

Location

Exton, Maryland

18. Funeral director

Exton, Maryland

Address

9/21 1948

19. (Date rec'd by registrar)

N.H. Neer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty TalbotCity or town Exton, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 19 48, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/13 19 47, to 9/20 19 48and that I last saw him alive on 9/20 19 48Immediate cause of death Embolism Cardiac DURATIONCarcinoma of Stomach

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations C. of Stomach

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. D. or other

Address _____ Date signed _____

RECEIVED

OCT 4 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09687

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 31 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Hurlock
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2(a) If veteran, name war ✓

3. (a) FULL NAME

Mr. Roma Beckwith

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

October 16, 1878

B. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

69

hrs.

min.

9. Birthplace

Dorchester County
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Mr. William B. Beckwith

13. Birthplace

Dorchester County

MOTHER

14. Maiden name

Emma Williams

15. Birthplace

Dorchester County

16. Informant

Mr. William Paul Beckwith

Address

Hurlock, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 15, 1948
(month) (day) (year)

Cemetery or crematory

Burial

Location

Hurlock

18. Funeral director

F. B. Milloughly

Address

Hurlock

19. (Date rec'd by registrar)

9/17/48

D. A. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 19 48 at 2:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 16 19 48 to Sept 16 19 48

and that I last saw him alive on Sept 16 19 48

Immediate cause of death Pulmonary embolus

DURATION

7 hrs

Due to Thrombo phlebitis

Due to years

Other conditions Obesity, chronic myo

carditis, hemorrhoids, diabetes.

(Include pregnancy within 8 months of death)

Major findings of operations Hypertrophied prostate

Date of op. Sept 2, 48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Schneider, M.D.

Easton Md Date signed Sept 17, 48

Address

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 197

09688

462

1. PLACE OF DEATH:

County Talbot
 City or town Easton, RFD #4
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Easton, RFD #4
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

EDGAR H. BURNS

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sadie B. Burns
 6. (c) If alive, give age 65 years
 7. Birth date of deceased (mo., day, yr.) September 6, 1883
 8. AGE: Years 65 Months 0 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace St. Michaels, Maryland
 (Town, county, and state)
 10. Usual occupation Merchant
 11. Industry or business _____

FATHER 12. Name James F. Burns
 13. Birthplace St. Michaels, Md.
 MOTHER 14. Maiden name Olivia Harrison
 15. Birthplace St. Michaels, Md.

16. Informant Mrs. Edgar H. Burns
 Address Easton, RFD #4, Md.

17. Burial Date thereof Sept. 27, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Olivet Cemetery
St. Michaels, Md.
 Location _____

18. Funeral director Newnam & Harrison
 Address St. Michaels, Md.

19. Sept 26, 1948 Mrs. Betty L. Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Sept 19 48 at 4:10 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Sept 19 48 to 27 Sept 19 48
 and that I last saw him alive on 23 Sept 19 48

Immediate cause of death Metastatic carcinoma of the rectum
 Due to Carcinoma of rectum
 DURATION 3-4 yrs.
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)
 Major findings of operations Carcinoma of rectum
 Date of op. 1939

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Robert Harrison M.D.
Carla Perry Land
 Address _____ Date signed 26 Sept 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 28 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

09689

292

1. PLACE OF DEATH:

County... Talbot
 City or town... near Trappe
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0
 Hospital, institution, or street address where death occurred:
In ambulance
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Dorchester
 City or town... Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 108 Cemetery Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Phillip Burgoyne (INfant) Cannon

3. (b) Social Security Number

none

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) September 6, 1948 6.(c) If alive, give age _____ years
 8. AGE: Years 0 Months 0 Days 0 It less than one day 6 hrs. _____ min.

9. Birthplace Cambridge, Dor., Md.
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business
 12. Name Phillip L. Cannon
 13. Birthplace Cambridge, Md.
 14. Maiden name Virginia Morean
 15. Birthplace Hurlock, Md.

16. Informant Phillip L. Cannon
 Address Cambridge, Md.
 17. Burial Date thereof 9/7/48
 (Burial, cremation, or removal, which?) (month) (day) (year)
Cambridge,
 Cemetery or crematory
 Location Cambridge, Md.
 18. Funeral director Le Compte Funeral Service
Cambridge, Md.
 Address

19. 9-9-48 John Mac. Jr. M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 19 48 at 6:30 a.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 19 48 to Sept 6 19 48
 and that I last saw him alive on Sept 6 19 48
 Immediate cause of death ERYTHROBLASTOSIS FETALIS DURATION BIRTH
 Due to
 Due to
 Other conditions none
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO
 Accident, suicide, or homicide NO Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other 9/7/48
 Address Cambridge Md Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 10 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 270

1. PLACE OF DEATH:

County Talbot
 City or town Coppersville (Easton R.)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Coppersville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. 2-5 Easton
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

Peter Copper
 4. Sex M 5. Color or race W 6. (a) Single, married, or divorced Widowed

6. (b) Name of husband or wife Katie Copper7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 Months Days If less than one day
 hrs. min.

9. Birthplace Talbot Co. Maryland
(Town, county, and state)10. Usual occupation Farmers

11. Industry or business

12. Name Peter Copper13. Birthplace Talbot Co.14. Maiden name Nancy Roberts15. Birthplace Talbot Co.16. Informant Earl L. Copper (son)Address Coppersville Md.17. Buried Date thereof Sept 13 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CoppersvilleLocation Talbot Co.18. Funeral director John H. HenryAddress 310 Benton St. Easton Md.9/12/48 N. H. Henry

19. (Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948, at 10:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1948 to Sept 9 1948and that I last saw him alive on Sept 9 1948Immediate cause of death Accidental death by a horse kickDURATION 10 hoursDue to Same as aboveDue to Same as above

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide at home Date of 9/9/48Where did injury occur? at home (City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury horse kick Injured at work? Yes23. SIGNATURE Harvard T. NeltAddress Easton Md. Date signed 9/9/48

1948
70
1878

RECEIVED
SEP 16 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Gr. V Palmer
468
09691
Reg. Dist. No. 290

1. PLACE OF DEATH:

County Ta. 1664
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

51

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Ta. 1664City or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. Mathewstown Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1948 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-13 1948 to 9/20 1948and that I last saw him alive on 9/20 1948

Immediate cause of death

Metastatic Carcinoma of liverDue to etiology unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Metastatic Carcinoma of liverAutopsy results Primary origin not determined

PHYSICIAN: Please sign and the cause of death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE J. A. Robt. MD M. D. or otherAddress Easton Md. Date signed 10/5/48

RECEIVED

OCT 16 1948

BUREAU 7. 5.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

175C

09692

FILE No. G 117 OCT 8 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Hall
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, institution, or street address where death occurred
Easton Memorial Hospital
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
City or town Edwards R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Thomas Wilbert Gould

3. (b) Social Security Number

1. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Rebecca Gould

7. Birth date of deceased (mo., day, yr.) April 2, 1898 6. (c) If alive, give age _____ years

8. AGE: Years 50 Months 5 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Caroline County
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business Charles Gould

12. Name Charles Gould

13. Birthplace Caroline County

14. Maiden name Caroline Brown

15. Birthplace Caroline County

16. Informant Rebecca Gould

Address Edwards, Md R.D. #2

17. Burial Date thereof 9/28/48
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Union

Location Near Greensboro, Md.

18. Funeral director Raymond B. Rawlings

Address Greensboro, Md.

19. 9/26 19 48 N.H. Morris
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 19 48 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Sept 48 to 25 Sept 48
and that I last saw him alive on 25 Sept 48

Immediate cause of death
Massive pulmonary embolus
Severe
Due to severe crural wound of left leg & fracture of left tibia
Due to fracture of left tibia
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9/3/48

Where did injury occur? Caroline Co.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) farm

Means of injury fall from hayrack Injured at work? yes

23. SIGNATURE B.T. Kinner M. D. or other yes

Address Edwards, Md Date signed 28 Sept 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 4 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this certificate are especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

48

N.H. Neeris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

24 Sept 48

Dr. Harrison
09693

131a



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Salisbury
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Aug. 22 to Sept 13, 1948
 Hospital, institution, or street address where death occurred: Memorial Hospital
 How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Maryland County Queen Anne's
 City or town Grassville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION) ✓

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Corey Saddler

3. (b) Social Security Number _____

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mena Saddler
 7. Birth date of deceased (mo., day, yr.) July 7, 1875
 6. (c) If alive, give age 65 years
 8. AGE: Years 73 Months 2 Days 5 It less than one day _____ hrs. _____ min.

9. Birthplace Grassville Md
(Town, county, and state)10. Usual occupation Retired11. Industry or business Farmer12. Name William Saddler13. Birthplace Maryland14. Maiden name Mary Collier15. Birthplace Maryland16. Informant Mena SaddlerAddress Grassville Md17. Burial Date thereof 9/15/48
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory ChesterfieldLocation Centerville Md18. Funeral director Barton BrosAddress Centerville Maryland19. 9/14 19 48 N.H. Neerues
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 19 48 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Aug 19 48 to 13 Sept 19 48
 and that I last saw him alive on 13 Sept - 48 19 48

Immediate cause of death chronic Nephritis
 DURATION _____

Due to _____

Due to _____

Other conditions Fract. Hip 22 Aug 48

(Include pregnancy within 3 months of death)

Major findings of operations Fract Hip 22 Aug 48
 Date of op. 28 Aug 48

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/22/48

Where did injury occur? Grassville Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury fall 11/13/48 Injured at work? ✓

23. SIGNATURE H. T. Kimmus MD
 M. D. or other _____

Address Earles Md Date signed 16 Sept 48

RECEIVED

SEP 25 1948

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

City or town Easton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

Memorial Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne

City or town Centerville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Betty Ann Scott, (late) BETTY ANN

3. (b) Social Security Number

4. Sex

F

5. Color or race

Cbl

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept-11-48 6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

7

hrs.

min.

9. Birthplace

Memorial Hospital, Easton, Md
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

48

N.H. Neer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 18

19.48, at 9:03 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-11

19.48, to

9-18

19.48

and that I last saw her alive on 9-18-

19.48

Immediate cause of death

Intercranial Hemorrhage

DURATION

Due to

Pneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy result

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

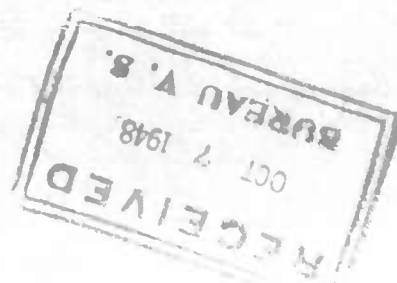
J. Tyler Baker M.D.

M. D. or other

Address

Easton

Date signed 9-27-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09697

Reg. Dist. No. 29

1. PLACE OF DEATH:
County Talbot
City or town Neavitt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Talbot
City or town Neavitt
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

George M. Thamert

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mary C. Thamert 6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) March 28 1875

8. AGE: Years 73 Months 5 Days 5 It less than one day hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

12. Name Joseph Thamert

13. Birthplace Baltimore, Md.

14. Maiden name Christine Wissner

15. Birthplace Germany

16. Informant John E. Thamert

Address Neavitt Talbot Co. Md.

17. Burial Date thereof Sept 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Neavitt Maryland

18. Funeral director Newnam & Harrison

Address St. Michaels Md.

19. Sept 3, 1948 Wm. B. L. L. L.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1948 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1947 to Sept 2, 1948

and that I last saw him alive on August 31, 1948

Immediate cause of death Coronary Thrombosis

DURATION

2 hrs.

Due to Hypertensive Cardio-Vascular

Renal Disease 10 yrs.

Due to Arteriosclerosis, generalized

severe 3

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury Injured at work?

23. SIGNATURE Arthur V. Michael

M. D. or other

Address St. Michaels, Md. Date signed 9-2-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County 2411
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs
 Hospital, institution or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD. County Isles
 City or town Isles
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

William Thomas Atkins Townsend

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Elen B. Townsend

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1866
 6. (c) If alive, give age _____ years

8. AGE: Years 81 Months 9 Days 25 It less than one day _____ hrs. _____ min.

9. Birthplace San Jose, Puerto Rico
 (Town, county) and state

10. Usual occupation Retired Railroad Agent

11. Industry or business _____

12. Name Elen B. Townsend

13. Birthplace MD.

14. Maiden name Margaret C. Clydesdale

15. Birthplace MD.

16. Informant Mrs. J. B. Marshall

Address Easton, Maryland

17. Burial Date thereof Sept. 11, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton, Md.

18. Funeral director Edwin C. ...

Address Easton, Md.

19. 9/10 19 48 N. H. ...
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 19 48 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1- 19 48 to 9-8- 19 48
 and that I last saw him alive on 9-8- 19 48

Immediate cause of death _____ DURATION _____

Nephrosclerosis 2 yrs

Due to arteriosclerosis, general 4 yrs

Due to _____

Other conditions Diabetes mellitus 10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other _____

Address Easton, Md. Date signed _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 294

1. PLACE OF DEATH:

County TalbotCity or town Claiborne
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Four years.Hospital, institution, or street address where death occurred:
Claiborne, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Claiborne
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lilla Alice Tribett

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 8- 1944
6. (c) If alive, give age _____ years8. AGE: Years Months Days If less than one day
4 1 17 _____ hrs. _____ min.9. Birthplace Mount Airey, Maryland.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name John C. Tribett13. Birthplace Silverton, West Virginia.14. Maiden name Edna R. Wood15. Birthplace Radford, Virginia.16. Informant Lilla TribettAddress Claiborne, Md.17. Burial Date thereof Sept. 20, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Olivet Cemetery.Location St. Michaels, Maryland.18. Funeral director Norman D. Marshall,Address St. Michaels, Maryland.19. Sept 20 1948 B. Wesley Sewell
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1948, at 1 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____,

and that I last saw him _____ alive on _____ 19_____,

Immediate cause of death Convulsions.

DURATION

1 hr.Due to acute intestinal indi-
gestion (toxemia).

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE S. Denny Wilson M.D.
M. D. or other _____Address St Michaels, Md Date signed Sept 18, 1948

1948-8-6

4-1-17

1948-9-17

RECEIVED

SEP 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09700

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Salbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 hrs 20 min

Hospital, institution, or street address where death occurred:

Memorial Hospital
How long in hospital or institution? 30 hrs 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Centerville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war. _____

3. (a) FULL NAME

Charles E. Tucker

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Florence Scott Tucker

7. Birth date of deceased (mo., day, yr.)

Oct 5, 1871

8. AGE:

Years

Months

Days

If less than one day

76

hrs. min.

9. Birthplace

Centerville Md
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

48

N.H. Nevins

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 16 - 1948 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

15 Sept 1948 to 16 Sept 1948and that I last saw him alive on 16 Sept 1948Immediate cause of death Cerebral vascular accident

Due to

Arteriosclerosis, General & Cerebral

Due to

Other conditions

Chronic alcoholism

DURATION

2 days

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thomas H. Henshaw M.D.

M. D. or other

Address

Catha, MarylandDate signed 17 Sept 48

RECEIVED

SEP 25 1948

BUREAU V. S.